



EMERGENCY MEDICAL CONSENT FORM

I _____, give my consent for authorized Stepping Stone, LLC staff member(s) to arrange emergency medical care and treatment for _____, if I cannot be reached or if a delay in treatment could result in further harm to consumers health.. In the event that my child/ consumer is injured or ill while under the care of the program, I hereby give permission to the facility to provide first aid for said child/ consumer and to take the appropriate measures, including contacting the Emergency Medical Service (EMS) system and/or arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my child/ consumer, I direct that the agency attempt to contact me. However, if medical care becomes absolutely essential, I give permission to the authorized Stepping Stone, LLC staff member(s) to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital, or their authorized designee. In furtherance of any treatment decisions to be made on my behalf for the benefit of my dependent, I give authorization to request, obtain, review and inspect any and all information bearing upon my child's/ consumer's health and relevant to any such decisions to be made respecting such treatment.

Policy holder's name is _____

Name of insurance is _____

Insurance Policy Number _____

Preferred Hospital/Treatment Center Name: _____

Hospital/Treatment Center Address: _____

☐ I understand that I assume all financial responsibility for any treatment or injuries sustained by my dependent.

Signature of Parent or Legal Guardian: _____

Date _____